

Metropolitan Public Health Department - Chronic Disease Program (615) 340-5613

DIABETES ESSENTIALS / KIDNEY DISEASE PREVENTION

COMPLETE, SIGN, AND FAX TO US AT: (615) 340-2150 with cover sheet.

PATIENT INFORMATION:

NAME: _____

DOB: _____ RACE: _____

ADDRESS: _____

CITY/ ZIP CODE: _____

HOME PHONE: _____ WORK: _____

ALTERNATE PHONE: _____

I authorize release of my medical records:

(Client Signature)

Insurance: _____

E-MAIL ADDRESS: _____

TODAY'S DIAGNOSIS: (PLEASE CHECK ONE)

<input type="checkbox"/>	250.02 DM Type2, uncontrolled	<input type="checkbox"/>	583.81 Kidney Disease Due to DM
<input type="checkbox"/>	250.03 DM Type1, uncontrolled	<input type="checkbox"/>	401.0 - 401.9 Hypertension

INCLUDE THESE LAB RESULTS OR FAX LAB REPORT

	Date	Result		Date	Result
HgbA _{1c}			BUN		
Microalbumin			Creatinine		
Chol			Hgb		
HDL			Hct		
LDL			GFR		
TG					

GROUP SETTING RECOMMENDED UNLESS BARRIERS TO LEARNING EXIST

Choose	EDUCATION SERVICES	DESCRIPTION
	Diabetes Essentials Workshop	<u>Recommended for newly diagnosed patients or those needing education.</u> Includes training in all content areas of diabetes education as recommended by the American Diabetes Association and American Association of Diabetes Educators.
	Kidney Disease Prevention Program	<u>Recommended for patients at increased risk for kidney disease.</u> This is a three-year education program to prevent renal decline. Labs will be requested yearly. Criteria for program includes one of the following: Diabetes, hypertension, microalbumin ≥ 30 , creatinine < 2.5 .

Comments

By signing, I certify that I am managing the beneficiary's healthcare and the training as described above is reasonable and necessary to ensure therapy compliance by providing skills and knowledge needed for them to manage their disease.

Physician/Practitioner Signature: _____ Print Name: _____

Name of Practice: _____ Date: _____